2 General Billing Information

2.1 Introduction

This section covers the basic billing information providers need to submit claims and adjustments to Idaho Medicaid. It describes Medicaid billing policies, how to submit Medicaid claims both electronically and on paper, how to check claim status, and where to get help with submitting claims. In addition, it describes the prior authorization (PA) process, third party liability, and adjustments (both electronic and paper).

Note: The provider handbooks are intended to provide basic program guidelines, however, in any case where the guidelines appear to contradict relevant provisions of the Idaho Code or rules, the code or rules prevail.

2.1.1 Medicaid Billing Policies

Once enrolled, providers may begin billing for services rendered to Idaho Medicaid participants. Providers are not obligated to accept all Medicaid participants on an ongoing, day-to-day basis. Provider enrollment signifies only that a provider may bill Medicaid.

Providers should charge their usual and customary fee for services and submit those charges to Medicaid for payment consideration.

Providers must accept payment from Medicaid as payment in full for services rendered if they bill Medicaid for covered services. Non-covered Medicaid services can be billed to the participant. Medicaid requires the provider to inform the participant prior to rendering service, if the service is not covered or if a particular covered service will not be billed to Medicaid, preferably in writing. If the participant agrees to pay for the service prior to the delivery of the service, then the provider may bill the participant for the entire amount of the fee.

If the participant has other insurance and the service is submitted for Medicaid payment, the provider must bill the third party insurance first, and then bill Medicaid. In this case, the participant cannot be billed for the difference between the Medicaid allowed amount and the usual and customary charge.

2.1.1.1 Service Limitations

Medicaid policy restricts certain services. These restrictions are referred to as service limitations. Each procedure and revenue code may be reviewed for a variety of limitation criteria. Examples of these criteria are:

- Same provider or regardless of provider.
- Time frame (yearly, calendar time period, or specific number of days).
- Number of dollars, per time frame.
- Units.
- Required justification (*e.g.*, reports, test results, time of treatment).
- Pregnancy.
- Age of participant.
- Lifetime procedures.

Some services with exceeded limitations may be covered with specific required justification or PA. See *Section 3 Provider Guidelines*, for specific service coverage and limitations for individual programs and specialties.

2.1.2 Timely Filing Limit

All claims must be submitted within 12 months (365 days) from the date of service. This is referred to as, timely filing.

2.1.2.1 Late Billing Documentation

All claim types must be submitted to Idaho Medicaid within 12 months, (365 days), from the date of service regardless of the participant's eligibility status. The only exception is Medicare crossover claims (explained below). To determine if a claim is within 12 months from the date of service, use the Julian date of the original 15-digit internal control number (ICN). See *Section 4.1.3 Internal Control Number (ICN)*, or *Section 5 Glossary,* for a description of ICN.

When the date on the initial claim exceeds the 12-month limit for timely filing, Medicaid will deny the claim unless the claim contains proof of timely filing. The only proof of timely billing is the original ICN. This ICN must be documented in the remarks field on all electronic or paper resubmissions. The ICN must indicate that the original claim was submitted within 12 months from the date of service. If the ICN of the original claim is not indicated on the resubmitted claim, the claim will be denied regardless if it was originally billed timely.

The remarks fields for a paper claim form are:

- Field **19** of the CMS-1500 claim form.
- Field **80** of the UB-04 claim form.
- Field **21** of the Pharmacy claim form.
- Field **61** on the ADA claim form.

For electronic claims the ICN can be indicated in the remarks field, except for pharmacy providers. Pharmacy providers must submit a paper claim.

If the participant has a third party insurance carrier, the claim for services must be submitted to Idaho Medicaid within 12 months of the date of service regardless of the date of payment or date of the Explanation of Benefits (EOB) from the other insurance carrier. The only exception is for Medicare crossover claims. If a Medicare claim is received, Medicaid will consider the claim for payment if it is within six months of the date of the Medicare payment on the Medicare EOB. For more information see *Section 2.5 Crossover Claims*, for crossover billing.

Claims for Idaho Medicaid participants who receive retro-eligibility must be submitted within 12 months of the date of service regardless of the date their eligibility was added.

Idaho Medicaid providers with a retro-active eligibility date must submit claims within 12 months of the date of service regardless of their enrollment date.

Claims for services requiring PA from the Department of Health and Welfare (DHW) or one of its agents must be submitted within 12 months (365 days) of the date of service regardless of when the PA was issued.

For Medicare claims filed in a timely manner, Medicaid will consider claims for payment within six months of the date of payment or date of the EOB of the Medicare claim. Attach a copy of the Medicare Remittance Notice (MRN) and submit the claim on paper or electronically if your software supports the transaction. Claims denied by Medicare for timely filing will in turn be denied by Medicaid, as not being timely.

Adjustments to paid claims must be made within two years after the calendar quarter in which the payment was received. Adjustments can only be done on paid claims or paid claim details. Denied claims or claim details must be resubmitted as a new claim.

2.1.2.2 Claim Processing Timeline

Claim Type	Description
Original Claims	Claim must be submitted within 12 months (365 days) of the date of service.
Denials	Claims should be resubmitted within 12 months (365 days) of the date of service. If more than a year has lapsed since the date of service, indicate original ICN in the remarks field on claim.
Other Insurance	Claim must be submitted within 12 months (365 days) of the date of service regardless of the date of payment or date of the EOB.
Participant Retroactive Eligibility	Claim must be submitted within 12 months (365 days) of the date of service regardless of the date the participant's eligibility was added.
Provider Retroactive Eligibility	Claim must be submitted within 12 months (365 days) of the date of service regardless of the enrollment date.
Medicare Crossover Claims; Paid	Claim must be submitted within 6 months of the date of payment or date of the EOB of the Medicare claim. (Attach MRN.) Medicare claims with valid denials are processed as straight claims – not Medicare Crossovers and are subject to the Medicaid 12 month requirement.
Adjustments for Paid Claims	Claim must be submitted within 2 years after the calendar quarter in which the payment was received.
Claims Requiring PA	Claim must be submitted within 12 months (365 days) of the date of service regardless of when the PA was issued.

2.1.2.3 Hospice Participants

Hospice care billings by non-hospice providers are considered on a case-by-case basis. Check with the Medical Care Unit for billing procedures. Any issues or questions concerning services for hospice participants regarding related or non-related charges should be referred to the hospice provider.

Division of Medicaid
Medical Care Unit – Hospice
PO Box 83720
Boise, ID 83720-0036
(208) 364-1818 in the Boise calling area
Fax: (208) 332-7280

2.1.2.4 Interpretation Services

Medicaid covers interpretation services to assist participants who are deaf or have limited English proficiency (LEP) to receive services from a fee-for-service provider.

Medicaid payment will be made to the provider when it is necessary for the provider to hire an interpreter in order to communicate with a participant when they are providing a direct service. For referrals to interpreter services in Idaho, call the Idaho Careline at **2-1-1** or toll-free **(800) 926-2588**. More information is available on the internet at **www.211.idaho.gov**, e-library, Interpreters.

Payment for interpretation services are subject to the following limitations:

- Payment for interpretation services will not be made to providers who cost audit settle with DHW. These services are considered to be included in the provider's cost of doing business. This includes providers such as hospitals, home health agencies, rural health clinics, and long-term care facilities.

- Payment will not be made for interpretive services to assist the participant to understand information or services that are not reimbursed by Medicaid.
- Payment will not be made for interpretive services when the provider of the service is able to communicate in the participant's language or sign language.

Bill for interpretation services with the following procedure codes:

8296A - Interpretive services

There is no difference in reimbursement if the interpreter is certified, partially certified, or non-certified and providing language services. This code pays per one hour unit. See the following link for the Information Release MA03-54 at: **www.healthandwelfare.idaho.gov/site/3430/default.aspx** for more information.

Effective December 1, 2006, providers billing for sign language interpretive services must use the following code:

T1013 - Sign Language Interpretive Services, per 15 minutes

2.1.3 Participant Billing Information

The participant's name is used in conjunction with the Medicaid identification (MID) number for identification when submitting claims. To avoid errors, verify participant eligibility every time, before services are rendered.

2.1.3.1 Medicaid Identification (MID) Number

Every Idaho Medicaid participant (including children) receives a unique 7-digit identification number. The MID is the only number accepted for processing claims. When entering the number on the claim form, do not use:

- Participant's Social Security number.
- Another family member's MID.
- Any letters, symbols, or hyphens.

2.1.3.2 Participant Name

It is important to enter the participant's name accurately. The EDS electronic billing software, PES, and the point of service (POS) device give a printed record of the spelling of the participant's name as it is on file with Medicaid. Common errors that are made when entering the name on the claim form include:

- Spelling mistakes, including not using participant's preferred spelling.
- Name not entered in correct order, or the participant may use a hyphenated last name.
- When entering a two word last name, not starting with the lead name (Example Van S. Glen Garry, Glen is the beginning of the last name not Garry).
- Use of a nickname from the provider's records instead of the proper name on file with Medicaid.
- Participant name has been changed and the participant has not updated their records with Medicaid or the provider.
- Parent's name used for minor child with a different last name.
- Typing errors.

2.1.4 Provider Signature and Number

All paper claims must have a valid provider signature and the 9-digit Idaho Medicaid provider number. Claims that are not signed and/or do not have a provider number are returned, whenever possible.

Form Available: A Signature-On-File form is included in the *Appendix D; Forms*.

2.1.4.1 Signature-on-File

Providers must sign every claim form or complete a Signature-On-File form. This form is used to submit paper claims without a handwritten signature and/or to submit electronic claims. This form allows submission of claims without a handwritten signature. It is used for computer-generated, signature stamp, or typewritten signatures. See *Section 1.1.4 Signature-on-File Form,* for more information.

2.1.4.2 Idaho Medicaid Provider Number

Paper claims cannot be processed without a valid Idaho Medicaid provider number. At the time of enrollment, each individual and group provider receives a unique number to use in the Idaho Medicaid Program. Provider numbers always have 9-digits with no spaces or hyphens. Do not use a Social Security or Federal Employer Identification Number (FEIN). Do not use a group number when an individual provider number is required, or vice versa.

Healthy Connection (HC) referral numbers are required to process claims for referred services. See *Section 3 Provider Guidelines,* for the correct field and location to document this information on your specific billing form.

2.2 Claims Submission

Providers may submit claims either electronically through Electronic Data Interchange (EDI) or on paper (hardcopy).

2.2.1 Electronic Claims Submission

Electronic Data Interchange (EDI) is the computer-based system that processes electronic claim transactions. Unless an attachment is required, all claims can be billed electronically using PES billing software (provided by EDS at no cost), a billing service, agency clearinghouse, or other vendor software (that has successfully tested with EDS). Unless they are using PES, all providers must have their software vendor or clearinghouse contact EDS to test software before claims can be submitted.

Electronic submission allows faster and more efficient claim submission and processing. Handling time, costs, and errors are reduced, eliminating the problems in processing that result in payment delays. Electronic claims can be submitted 24 hours a day, seven days a week.

Note: A HIPAA formatted electronic claim for professional, dental, or institutional service is called an 837 transaction.

A HIPAA formatted electronic claim for retail pharmacy services is called an NCPDP transaction.

A HIPAA formatted electronic Remittance Advice (RA) is called an 835 transaction.

All providers, except retail pharmacies, who bill electronically, must submit claims in the HIPAA compliant 837 transaction format, version 4010A1. Retail pharmacy providers who bill prescription drugs electronically must use the HIPAA NCPDP 5.1 format.

The National Provider Identifier (NPI) is part of HIPAA. The NPI number or numbers will replace existing provider numbers on electronic claims and will identify healthcare providers to health plans with a unique 10-digit numeric provider identifier. Based upon the federal NPI requirements, healthcare providers who have an NPI must use their NPI number for electronic claims and eligibility transactions.

- Providers must register their NPI(s) with Idaho Medicaid online at: **https://npi.dhw.idaho.gov**.

To apply for your NPI, go to the following Internet site: **https://nppes.cms.hhs.gov/NPPES/Welcome.do**, or call: **(800) 465-3203 (toll free)** for a paper application.

Some Idaho Medicaid providers will be able to continue using their current Idaho Medicaid provider number on both electronic and paper claims and will not be expected to send an NPI on their claims. Idaho Medicaid has interpreted the NPI rule to designate the following provider types as non-healthcare providers, also known as, atypical providers:

- Non-emergency commercial transportation.
- Transportation broker.
- Individual transportation provider.
- Agency transportation provider.
- Personal emergency response systems.
- Home modifications.
- 24-hour Personal Care Service (PCS) home for children – (Foster Care).

- PCS/Aged and Disabled (A&D) Agency.
- Adult day care.
- Residential Assisted Living Facility (RALF).
- Behavior Consultation/Crisis Management.
- Chore services.
- Home delivered meals.
- Self-determination fiscal employer agent.
- Residential habilitation agency.
- Certified family homes.
- Respite care.
- Supported employment service.

Electronic claims that are not in the correct HIPAA compliant format will be rejected.

Because providers use a variety of different billing software, it is not possible to give exact information on how to complete any specific electronic eligibility or claim form. Providers can review the *Provider Electronic Solutions (PES) Handbook* for a general example of eligibility and billing software.

2.2.1.1 EDS' Billing Software - Provider Electronic Solutions (PES)

EDS has developed and distributed software to all Idaho Medicaid providers to submit claims and check participant eligibility. The EDS software is also referred to as PES.

The PES software contains forms to submit electronic transactions by diskette or modem. Electronic transactions include eligibility verification, and submission of professional, dental, institutional, and pharmacy claims. The software comes loaded with commonly used lists, for example, place of service values and other insurance carrier information. In addition, the user can create lists of information regularly used in forms such as participant names and procedure codes. The software also generates reports to track the information submitted within the claims.

The system requirements for PES are:

Minimum	Recommended
• Pentium II with CD-ROM	• Pentium II with CD-ROM
• Windows 2000/XP	• Windows 2000, NT, ME, XP
• MS Internet Explorer 5.5 or greater	• MS Internet Explorer 5.5 or greater
• 64 Megabytes RAM	• 128 Megabytes RAM
• 800 X 600 Resolution	• 1024 X 768 Resolution
• 28.8 Baud rate modem or faster is preferred	• 33.6 Baud rate modem or faster
• 100 MB Free Hard Drive Space	• 100 MB Free Hard Drive Space
• CD-ROM	• CD-ROM
• Printer with 8pt MS Sans Serif is preferred	• Printer with 8pt MS Sans Serif

2.2.1.2 Vendor Software and Clearinghouses

Providers can use electronic claims submission software from other vendors after it is tested to comply with the Idaho Medicaid EDI system. Contact the EDS Help Desk for assistance in running test claims before submitting large batches for the first time with new or upgraded software.

Providers who wish to bill electronically and who bill to more than one insurance carrier should consider using a clearinghouse. Clearinghouses are private companies that handle insurance claims for multiple providers. The advantage for the provider is that claims are keyed only once for the clearinghouse. The clearinghouse then forwards the claim to the appropriate insurance carriers (including Idaho Medicaid).

EDS will furnish the specifications, free of charge, to any vendor upon request. The specifications assist the vendor in duplicating the program requirements to allow a provider to obtain the same information available as using software supplied by EDS. All vendor software must be successfully tested with EDS before use. Once the vendor or clearinghouse has successfully transmitted sample data to the Idaho Medicaid system, providers using their services may begin using the vendor software or clearinghouse to submit claims.

Providers, vendors, and clearinghouses should contact EDS to arrange testing. When testing has been completed, claims may be submitted for processing. Contact EDS, Technical Support at: **(800) 685-3757** (toll free)

Form Available: The Electronic Claims Submission Certification and Authorization form is included in *Appendix D; Forms.*

It can also be used to request free software from EDS.

2.2.1.3 Electronic Claims Submission Agreement

All providers who wish to bill electronically, must submit a completed Electronic Claims Submission Certification and Authorization form and receive a submitter identification and password from EDS. See *Appendix D; Forms*.

2.2.1.4 Health Insurance Portability and Accountability Act (HIPAA) Required Data Elements

When billing electronically, providers must complete all HIPAA required data elements; however, not all of the information is used by Idaho Medicaid in claims processing. The following HIPAA required data elements for an electronic HIPAA 837 claim submission are not used by Idaho Medicaid:

- Release of medical data.
- Benefit assignment.
- Patient signature.
- Social Security number.
- Tax identification number and qualifier.
- Entity type qualifiers.
- Provider and participant address.
- Participant identification qualifier.
- Participant date of birth.
- Participant gender.

2.2.2 Paper Claim Forms

Several different types of claim forms are used to bill services to Medicaid. All paper claims are electronically scanned for processing. The printed versions of the claim forms are machine readable. As such, they are printed using special paper, special color inks, and within precise specifications. For this

reason, only original, color forms can be used for scanning. Forms that cannot be scanned are returned to the provider.

To ensure that claims are scanned correctly, follow these guidelines.

2.2.2.1 Completing the Form

Use an original, color claim form. Black copies cannot be scanned.

See *Section 3 Provider Guidelines,* for your specific provider type in this handbook for the required fields. When billing Medicaid there is no need to enter data into fields that are not required.

- Use black ink.
- Use a typewriter with a good ribbon or a printer with a good ink cartridge. Change the ribbon or ink source if the print is too light.
- When using a typewriter or printer, make sure the form is lined up correctly so it prints evenly. Claims cannot be processed when the information is not in the correct field.
- If completing the form by hand, print neatly.
- Be sure to stay within the box for each field.
- When entering an X in a check-off box, be sure that the mark is centered in the box.
- Use correction tape to cover errors.
- Use yellow or pink highlighting pens to mark information on a claim. Other colors appear as a black bar and the text is obscured.

2.2.2.2 Mailing the Form

Do not staple any attachments to the form. Check *Section 3 Provider Guidelines,* for your specific provider type in this handbook to see if an attachment is required. Providers are urged to bill electronically when no attachments are required.

Do not fold the form. Mail it flat in a 9 x 12 envelope (minimum size). Mail to:

EDS
PO Box 23
Boise, ID 83707

Send correspondence in a separate envelope or mark the outside of the claim envelope, *Correspondence Enclosed*.

2.2.2.3 Entering a Provider Identification Number on a Paper Claim Form

Claims submitted on the CMS-1500 claim form require the following fields:

Field	Field Name	Use	Description
33	Billing Provider Info & PH. #	Required	Enter the name and address exactly as it appears on the provider enrollment acceptance letter or RA. **Note:** If you have had a change of address or ownership, please, immediately notify Provider Enrollment, in writing, so that the provider master file can be updated.
33A	NPI	Optional	Enter the 10-digit NPI number of the billing provider. **Note:** NPI numbers, sent on paper claims are optional and will not be used for claims processing.

Field	Field Name	Use	Description
33B	Blank Field	Required	Enter the qualifier **1D** followed by the provider's 9-digit Idaho Medicaid provider number with no spaces in between. (*e.g.* 1D123456789) **Note:** All paper claims require the 9-digit Idaho Medicaid provider number with the **1D** qualifier for successful claims processing.

See *Section 3 Provider Guidelines,* for your specific provider type under claim form billing for more information.

2.2.3 Attachments

Attachments are additional documentation required to submit a claim for processing. Attachments may include:

- Third Party Explanation of Benefits (EOB).
- Explanation of Medicare Remittance Notice (MRN).
- Certificate of Medical Necessity (CMN).
- Pharmacy prescription.
- Consent forms.
- Manufacturer's invoice.

If no attachments are required, then consider submitting the claim electronically.

If a claim has an attachment, do not staple or clip it to the claim. Place it behind the claim form.

If multiple claims refer to the same attachment, then make separate copies of the attachment for each claim.

If multiple claims are sent together, then stack the claims with each claim followed by its own attachment(s).

If an attachment has information on both sides of the page, then make a copy of the backside and include it with the claim.

If an attachment such as a sales receipt is on a small slip of paper, then copy or tape it onto an 8½ by 11 inch piece of paper.

It is not necessary to include the Medicaid RA as an attachment.

2.2.3.1 Examples of Documentation Necessary for Billing

Actual Example	Required Documentation	Solution
Three claims submitted for the same participant with one EOB included with the claims.	One copy of the EOB for each claim	Submit all three claims on one claim form and include one EOB. or Submit three claims and include one EOB with each claim.
Four corrected claims submitted that had previously been denied. Remittance Advice (RA) explaining why claims had previously been denied is included.	None	Do not include RA with claim. When the date on the claim exceeds the timely filing limit (one year from date of service, 365 days) enter the ICN from the RA in the comment field of the claim.

Actual Example	Required Documentation	Solution
Three claims submitted for the same participant and one copy of a Healthy Connections (HC) referral included.	None	Submit one claim for all the services and enter the HC referral number in the correct field.
Two claims submitted, the first is marked *continued,* and one attachment is included to explain the use of a 'dump' code for a lab test.	None	Total each claim separately and enter the name of the lab test in field **19**.
Two claims submitted with one prescription attached.	One copy of the prescription for each claim	Include one prescription copy with each claim form.

2.2.4 Claim Status

There are three types of claim status: Pended, denied, and paid. Providers can determine the status of their claims three ways: Through the weekly RA, by calling Medicaid Automated Voice Information Service (MAVIS), and with the 276/277 electronic claim status request and response transaction.

Note: The 276/277 electronic claim status request and response is not a transaction supported by PES.

Remittance Advice (RA): See *Section 4 Remittance Advice (RA) Guidelines*, for information.

MAVIS Inquiry: Providers can check the status of electronic and paper claims sent to EDS for processing by calling MAVIS and selecting the *claims information* option. For more information on how to access MAVIS and check claim status, see *Appendix C; MAVIS*.

Electronic Inquiry: Idaho Medicaid supports the HIPAA transaction known as the 276/277, Electronic Claim Status Inquiry and Response. This transaction allows providers to electronically inquire on the status of claims and requires health plans to return an electronic response. A claim status inquiry (276) can be sent with only a claim number or with the participant Medicaid identification (MID) number, participant last and first name, gender, and date of birth. Claim category and status codes will be returned in the claim status response (277). EDS will process the 276/277 transactions on a daily basis.

Providers should contact their software vendor or clearinghouse to determine if they support the claim status inquiry and response. PES, the EDS claims and eligibility software, does not support the 276/277 transaction.

2.3 Prior Authorization (PA)

2.3.1 Overview

Federal regulations permit Medicaid to require PA for any service where it is anticipated or known that the service could either be abused by providers or participants, or easily result in excessive and uncontrollable Medicaid costs. Prior authorization is required before certain services are delivered to a participant. The Department of Health and Welfare (DHW) and private contractors maintain the PA process. All claims for all services that require PA must include the PA number on the claim, whether the claim is electronic or paper.

For PA addresses and telephone numbers, see the *Directory* at the beginning of this handbook.

Depending on the service, PA is available from:

- Division of Medicaid's Central Office.
- Regional Developmental Disabilities Program.
- Medicaid Non-Emergent Transportation Unit.
- Regional Medicaid Services (RMS) Unit.
- Regional Mental Health Authority (RMHA).
- Qualis Health (a private contractor).

It is the provider's responsibility to verify the participant's eligibility on the date of service and request any required PA. Read through this section of the handbook for more detailed information on specific services that require PA.

Note: Receiving a PA for services does not guarantee payment. The participant must be eligible on the date authorized services are rendered.

The Department of Health and Welfare requires PA for the following general areas of service:

- Case management services.
- Home and community based waiver services for the following waivers:
  - Developmental disabilities.
  - Aged and disabled/traumatic brain injuries.
- Personal care services (PCS).
- Some durable medical equipment (DME) purchases and rentals.
- Cosmetic and reconstructive surgery.
- Miscellaneous DME supplies totaling over $100.00 per month.
- Some prosthetics and orthotics.
- Selected hospital inpatient/outpatient procedures.
- Selected optometric services.
- Selected prescription drugs.
- Some physical therapy services.
- Selected surgical procedures.
- Services/procedures identified as necessary in an Early Periodic Screening Diagnosis and Treatment (EPSDT) that are outside the scope of Idaho Medicaid coverage, such as private duty nursing.

- Some dental surgery and items.
- Surgery related to obesity.
- Transplants.
- Transportation by an ambulance or individual/commercial transportation provider for non-emergency Medicaid covered services from an Idaho Medicaid medical provider.
- Any urgent/emergency inpatient or outpatient treatment where the procedure or diagnosis code appears on the select pre-authorization list must be reviewed by Qualis Health within one working day of admission. Those surgical procedures on the select pre-authorization list must be authorized regardless of the place of service. The diagnoses on the select pre-authorization list are for inpatient only.

2.3.2 Medicaid Prior Authorization (PA)

To render a service that requires Medicaid PA, write a letter to Medicaid and attach documentation justifying the medical necessity of the procedure.

Direct all requests for PA to the appropriate contractor or department unit as listed in, *Section 3 Provider Guidelines*. The requests should include:

- Participant name and Medicaid identification (MID) number.
- Signed physician's order.
- A list of all items and a price quote for each.
- Prescriber's statement of diagnosis and medical necessity for applicable drugs.
- Requesting provider.

If a HC participant, include the HC referral number.

Regarding PA Requirements: PA numbers must be included on all claims for services that require PA.

Professional and dental providers can use more than one PA number on electronic claims.

Medicaid issues a written notification of authorization or denial for all written requests for PA. A PA number is assigned to all approved PAs. Enter the PA number in the designated field on the claim; do not attach the PA letter. Professional and dental electronic claims may include multiple PA numbers on each claim.

The PA letter indicates the length of time the authorization is valid. The dates of service being billed must occur on or after the start date and on or before the expiration date indicated on the PA letter. If the PA expiration date occurs before services are provided, a new PA must be requested. To prevent a disruption or break in service to the participant, request PA as soon as the need for additional services is identified.

Claims that require PA may be submitted electronically. Note the PA number in the appropriate field and use the procedure codes and units of service as authorized on the PA letter.

Dental: Dental prior authorization requires submission of the general or orthodontic prior authorization form to the Medicaid Dental Consultant. See *Section 3 Dental Guidelines*, for specific prior authorization request procedures.

Pharmacy: Pharmacy providers apply for PA from the Division of Medicaid. The Division returns the PA letter with a PA number. The provider submits the claim with the PA number to EDS. See *Section 3 Pharmacy*, for more information on the pharmacy PA process or the Pharmacy Program Information on the Internet at: **http://www.healthandwelfare.idaho.gov**.

All Providers: Whether billing electronically or on paper, all providers who bill services requiring PA must include the PA number on their claims. If a claim doesn't have a PA number on it or does not match the PA on file, then the claim will be denied.

2.3.2.1 Electronic Billing with Prior Authorization (PA)

Idaho Medicaid allows professional and dental providers who submit electronic claims to include multiple PA numbers on one claim. When necessary, providers can send PA numbers at both the header and detail level. (See examples as follows.)

- If a provider sends a PA at the header and no PA at the detail, the header PA will apply to the whole claim.
- If a provider sends a PA at the detail and no PA at the header, the PA number will apply to that detail only.
- If a provider submits multiple services and sends a PA at the header, which applies to some of the services, and a different PA at the detail, Medicaid will process the PA at the detail first against the detail service. Medicaid will process the remaining details using the header PA.

  Note: Paper claims (regardless of provider type), electronic institutional, and electronic pharmacy claims can use only one PA for each claim.

For PA addresses and telephone numbers, see the *Directory* at the beginning of this handbook.

2.3.2.2 Prior Authorization (PA) Number Format on Claims

When billing electronically using PES software, add enough zeros at the beginning to create an 8-digit number. Example: 654321 becomes 00654321. Do not add zeros at the end; it will cause the claim to deny.

When completing a paper claim, enter the PA number in the appropriate field exactly as it is given on the PA notification. Do not add zeros.

2.3.3 Regional Medicaid Services (RMS) Prior Authorization (PA)

The RMS Unit is responsible for PA for:

- PCS.
- Home and Community Based Waiver Services (HCBS) for the elderly, persons with physical disabilities, and traumatic brain injuries (TBI).
- PCS case management.
- Private duty nursing for children under the EPSDT Program.

  Note: Private duty nursing is authorized by the RMS for participants under age 21.

If completion of a form is required for the request, the RMS will provide the appropriate form.

The RMS Unit issues a written notification of PA or denial for all submitted requests. A PA number is assigned to each request. Enter the PA number in the appropriate field on the CMS-1500 claim form or in the appropriate field of the electronic claim form. There is no need to attach the PA notice to the claim when billing, however the claim must match the prior authorized procedure codes, authorized dates of service, and diagnosis exactly.

2.3.4 Developmental Disabilities (DD) Program Prior Authorization (PA)

The case manager submits an Individual Support Plan (ISP) to the Regional DD Unit to request PA for waiver services for adult DD service coordination and EPSDT service coordination. The ISP form may be obtained from the Regional DD Unit.

The Access to Care Coordination, Evaluation, Services, and Supports Unit (ACCESS) issues a written notification of PA or denial for all submitted requests. A PA number is assigned to each request. Enter the PA number in the appropriate field on the CMS-1500 claim form or in the appropriate field of the electronic claim form. There is no need to attach the PA notice to the claim when billing, however the claim must match the prior authorized procedure codes, authorized dates of service, and diagnosis exactly.

Note: The Medicaid participant or participant's representative must obtain a PA before the provider renders services.

2.3.5 Medicaid Transportation Prior Authorization (PA)

Call Medicaid Transportation to request PA of the following services:

- In state and out-of-state, non-emergency medical transportation and related necessary expenses to receive covered medical care and treatment, if no other free resources.
- Lodging and meals for participant and attendant when necessary.
- Requests for PA must be received at least 24 hours prior to the time requested services are to be provided.

Transportation PAs are available by calling:

(208) 334-4990 in the Boise calling area
(800) 296-0509 (toll free)
Fax: (800) 296-0513

2.3.6 Quality Improvement Organization (QIO) Prior Authorization (PA)

The Division of Medicaid contracts with Qualis Health, a QIO to conduct medical necessity reviews on a pre-admission basis for selected diagnoses and procedures. Qualis Health also conducts concurrent review of all inpatient admissions that exceed a specified number of days and retrospective reviews when necessary. For specific instructions on how to request these reviews, see the Qualis Health Idaho Medicaid Provider Manual (on the internet at: **http://www.qualishealth.org/cm/idaho-medicaid/manual.cfm** or contact the QIO directly at:

Qualis Health
PO Box 33400
10700 Meridian Avenue North, Suite 100
Seattle, WA 98133-0400
(800) 783-9207 (toll free)
Fax: (800) 826-3836

If transportation services are requested for an out-of-state admission, they must be prior authorized by Medicaid Transportation.

See the *Qualis Health Provider Manual 2009,* available on the internet at:
http://www.qualishealth.org/cm/idaho-medicaid/manual.cfm

2.3.7 Requests for Reconsideration and Appeals

Providers and participants may appeal a PA decision made by DHW or its designee, by following these steps:

Step 1 Carefully examine the Notice of Decision for Medical Benefits to ensure that the service(s) and requested procedure code was actually denied, (see, Status). Occasionally a requested service/procedure code has been denied and the appropriate service/procedure code was actually approved on the next line in the notice. If the provider or participant feels that an inappropriate denial of service has occurred, the next step is to submit a written, Request for Reconsideration.

Step 2 **Request for Reconsideration:** Prepare a written Request for Reconsideration, which includes any additional extenuating circumstances and specific information that will assist the authorizing agent in the reconsideration review. Resubmit to the authorizing agent within 28 days from the mailing date of the, Notice of Decision for Medical Benefits.

Upon completion of the reconsideration review, DHW will issue a second, Notice of Decision for Medical Benefits. If the provider or participant disagrees with the PA reconsideration decision made by DHW or its designee, they may file a Request for Appeal. The provider or participant

has 28 days from the mailing date of the second, Notice of Decision for Medical Benefits, to submit a formal appeal.

Step 3 **Request for Appeal:** To submit a written request for an appeal of the decision, follow the steps below. Documentation may be faxed but the fax must be followed with copies of original documents in the mail.

- Prepare a written request for an appeal that includes:
  - A copy of the Notice of Decision for Medical Benefits from the authorizing agent.
  - A copy of the Request for Reconsideration from the provider/participant.
  - A copy of the second Notice of Decision for Medical Benefits from the authorizing agent showing that the request for reconsideration was performed.
  - An explanation of why the reconsideration remains contested by the provider/participant.
  - Copies of all supporting documentation.
- Mail the request and additional information to:

  Hearings Coordinator
  Idaho Department of Health and Welfare
  Administrative Procedures Section
  PO Box 83720
  Boise, ID 83720-0036
  Fax: (208) 334-6558

Step 4 **QIO Appeals:** The advisory letter sent from the QIO to physicians and hospitals gives two types of appeal options, expedited and standard. Appeals for non-certification or partial certification decisions must be completed with Qualis Health review before submitting an appeal to the department's hearings coordinator.

- **Expedited Appeal:** An expedited appeal must be requested by telephone, fax, or in writing within two business days after notification. Qualis Health will complete the appeal within two business days from the receipt of the request. If you disagree with the results of the expedited appeal determination or have not submitted one, you have the option of requesting a standard appeal.
- **Standard Appeal:** The standard appeal request must be submitted within 180 days of receipt of the advisory letter from Qualis Health. Another peer physician will review the medical records and any new information you submit. You will be notified of the determination within 30 days. If you disagree with the final decision, you may then request DWH appeal, also referred to as a contested case hearing appeal.
- **Department Appeal:** A contested case hearing may be requested from DHW after the appeal process is exhausted with Qualis Health. The appeal must be received in writing by the department's hearings coordinator, Administrative Procedures Section (see address above), within 28 days from the mailing date of the advisory letter. A copy of the final determination letter from Qualis Health attached to your appeal will help expedite your request. You will be notified in writing by a hearing officer to set up a date, time, and location for the hearing.

2.4 Third Party Recovery (TPR)

2.4.1 Overview

This section covers the TPR situations that may apply to providers working with Idaho Medicaid participants. It briefly describes how EDS processes TPR claims. In accordance with federal regulations 42 CFR-433.135-139, the Division of Medicaid or its designee must take all reasonable measures to determine the legal liability of third parties to pay for medical services under the plan.

A third party is any insurance company, private individual, corporation, or business that can be held legally responsible for the payment of all or part of the medical or dental costs of a participant. Third parties could include:

- Group health insurance.
- Workers' compensation.
- Homeowners' insurance.
- Automobile liability insurance.
- Non-custodial parents or their insurance carriers.
- An individual responsible for a Medicaid participant's injury (a person who committed an assault on a participant, for instance).

Federal regulations require providers to bill all known insurance companies before submitting a claim to Medicaid. See *Section 2.4.2 Exclusions*, for the exceptions to this requirement.

To verify other insurance information, call Medicaid Automated Voice Information Service (MAVIS) at:

383-4310 in the Boise calling area
(800) 685-3757 (toll free)

MAVIS is available 24 hours a day including weekends and holidays, except during scheduled system maintenance. MAVIS will inform the caller if the system is unavailable.

2.4.1.1 Participant Responsibility

The provider must accept the Medicaid allowed amount as payment in full. The provider cannot bill the participant for any balance remaining after the primary insurance and Medicaid have both paid.

2.4.2 Exclusions

Services excluded from TPR requirements are:

- Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program services.
- Prenatal.
- Non-emergency medical transportation.
- Personal care services (PCS).
- Mental health (MH).
- Developmental disability (DD).
- Health related services provided by Idaho Public School Districts.

Providers who bill for these services are not required to bill the third party before billing Medicaid.

2.4.3 Determining Other Insurance Coverage

Use MAVIS, a point of service (POS) device; submit an inquiry through PES, or other successfully tested vendor software to determine if a participant has other insurance coverage before billing Idaho Medicaid. The system lists the name of the insurance company if it is one of the top 100 companies identified by Idaho Medicaid and the type of coverage. If there is other insurance coverage, note the information on the other insurance carrier and bill the other insurance before billing Medicaid.

See *Section 2.4.3.1 Third Party Recovery (TPR) Coverage Codes*, for a complete listing of the TPR coverage codes and their descriptions.

See *Section 2.4.3.2 Third Party Recovery (TPR) Carrier Codes,* for a listing of the top insurance companies identified by Idaho Medicaid.

2.4.3.1 Third Party Recovery (TPR) Coverage Codes

Code	Description
0001	Full coverage.
0002	Full coverage, no dental.
0003	Full coverage, no dental, no drugs.
0004	Full coverage, no vision.
0005	Full coverage, no dental, no vision.
0006	Accident only policy.
0007	Hospital only policy.
0008	Surgical policy.
0009	Accident & hospital only.
0010	Cancer only policy.
0011	Dental only.
0012	Drug only.
0013	Vision.
0014	Medicare Part A.
0015	Medicare Part B.
0016	Medicare supplement, no drug.
0017	Full coverage with dental, no drug.
0018	Medicare supplement with drug.
0019	Full coverage, no long-term care (LTC).
0020	Full coverage, no dental, no LTC.
0021	Full coverage, no drug, no LTC.
0022	Full coverage, no vision, no LTC.
0023	Full coverage, no dental, no drug, no LTC.
0024	Full coverage, no dental, no vision, no LTC.

Code	Description
0025	Full coverage, no dental, no vision, no drug.
0026	Full coverage, no dental, no vision, no drug, no LTC.
0027	Medicare HMO.
0029	Unknown.
0038	Air ambulance coverage.
0039	LTC/nursing home coverage.
0040	Full coverage and LTC, no vision, no drug.
0041	Medicare HMO.
0042	Medicare Advantage, Part A & B only.
0043	Medicare Advantage, Part A & B with drug.
0044	Medicare Advantage, Part A & B with dental.
0045	Medicare Advantage, Part A & B with dental and drug.
0046	Medicare Advantage, Part A & B with vision.
0047	Medicare Advantage, Part A & B with drug and vision.
0048	Medicare Advantage, Part A & B with dental and vision.
0049	Medicare Advantage, Part A & B with dental, vision, and drug.
0050	Medicaid/Medicaid Coordinated Plan.

2.4.3.2 Third Party Recovery (TPR) Carrier Codes

Carrier Code	Carrier Name
00010	Utah/Idaho Teamsters Health and Welfare.
00011	Railroad Employees.
00012	Blue Shield of Idaho (Regence).
00014	Mail Handlers.
00020	Palmetto Government Benefit Admin.
00025	Oregon Life & Health.
00037	Bankers Life & Casualty.
00038	Regence Life And Health.
00039	Blue Cross Of Idaho.
00041	Blue Cross Of Washington/Alaska.
00051	Union Bankers Insurance.
00053	Deseret Mutual Benefit.
00058	First Health.
00059	TPM/Timber Product Management.
00062	NALC Health Benefit.

Carrier Code	Carrier Name
00063	Lamb-Weston Gr Claim.
00068	Globe Life & Accident.
00070	I E C/Ameri-Ben Solutions.
00074	Administration Service.
00077	Medical Services Corporation (MSC).
00079	Mutual Of Omaha.
00083	Physicians Mutual.
00102	GEHA.
00124	First Health.
00148	Iowa Benefits.
00158	Blue Cross Of California.
00160	Great West Life.
00162	Lamb Weston.
00173	Group Health Northwest.
00192	Blue Cross/Blue Shield Of Utah.
00194	Group Health Northwest.
00197	Jensen Administrative Services.
00213	Blue Cross Of Idaho.
00221	Wall-Mart Benefits.
00228	CIGNA.
00246	Highmark B C B S of Pennsylvania.
00253	Boise Cascade Insurance.
00266	CIGNA.
00296	Health Med/Qualmed.
00302	United Health Care.
00303	First Health.
00307	Washington-Idaho Operating Engineer.
00310	First Health HP Employees.
00314	Blue Cross of Pennsylvania.
00337	HMO Blue.
00347	United Health Care.
00364	Mega Life & Health.
00367	United Health Care.
00380	AETNA/Prudential.

Carrier Code	Carrier Name
00433	United Health Care.
00437	AARP.
00447	AETNA.
00485	MEGA Life & Health.
00489	Combined Insurance.
00504	Educators Mutual.
00555	AETNA.
00577	Lincoln National.
00597	Principal Financial/JR Simplot.
00615	IHC.
00639	Retail Clerks Trust.
00751	CIGNA.
00752	Heller Associates.
00813	Principal Financial.
00821	First Health RX (Alta RX).
01110	Benesight/Third Party Administrator.
MEDA	Medicare Northwest.
MEDB	Medicare CIGNA.
MMCP	Blue Cross of Idaho MMCP.
RRA	United Healthcare.
RRB	United Healthcare.

2.4.4 Processing Third Party Recovery (TPR) Claims

After receiving either a partial payment or a denial from an insurance company, submit the claim to Medicaid for payment consideration along with a copy of the Explanation of Benefits (EOB).

- If the insurance payment is more than 40 percent of the billed amount, no EOB is required for the claim.
- If the insurance payment is less than 40 percent of the billed amount, the provider must include the insurance company's EOB with the claim.
- If the insurance is Medicare, a Medicare Remittance Notice (MRN) is always required.

When submitting the claim to Medicaid, verify that the dates of service, units, and charges are the same on the primary insurance EOB and on the claim to Medicaid.

If the other insurance carrier paid no services on the claim, submit the claim to EDS for processing. A copy of the other insurance company's EOB must be attached to the claim to document the other insurance company's denial. The denial must be valid before the claim can be processed.

A paper EOB from the other insurer is included with paper claims, including the EOB message from the other insurance. Since there are hundreds of insurers, each with their own coding system, Idaho Medicaid cannot process a claim unless the EOB number and message is included with the paper claim.

Fill in the other insurance paid amount in the appropriate field of the claim. If the insurance pays at zero, (0.00) must be recorded in the appropriate field or the claim will be denied. These claims can be submitted electronically with the Medicaid TPR adjustment reason code (ARC) in the appropriate field.

2.4.4.1 Electronic Third Party Claims

HIPAA ARCs replace the third party EOB codes that were formerly used on electronic third party claims.

These codes are used to explain the payment of benefits for a claim. After the claim has been submitted to the primary insurance carrier and processed, these codes are used to explain how the claim was processed. ARC describes the action taken by the other payer. For electronic claims, the current ARC is required on all TPR transactions.

Submit paper claims with the required EOB which includes the ARC. Use the code that best explains how benefits were processed (paid or not paid). Additional ARC information is available at: **http://www.wpc-edi.com/custom_html/claimadjustment.htm**

Further information can be obtained online at: **http://www.healthandwelfare.idaho.gov**, or call MAVIS at: **383-4310** in the Boise calling area or at: **(800) 685-3757** (toll free).

2.4.4.2 Adjustment Reason Codes

Code	Description
1	Deductible amount.
2	Coinsurance amount.
3	Co-payment amount.
4	The procedure code is inconsistent with the modifier used or a required modifier is missing.
5	The procedure code/bill type is inconsistent with the place of service.
6	The procedure code is inconsistent with the patient's age.
7	The procedure code is inconsistent with the patient's gender.
8	The procedure code is inconsistent with the provider type.
9	The diagnosis is inconsistent with the patient's age.
10	The diagnosis is inconsistent with the patient's gender.
11	The diagnosis is inconsistent with the procedure.
12	The diagnosis is inconsistent with the provider type.
13	The date of death precedes the date of service.
14	The date of birth follows the date of service.
15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.
16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice (RA) remarks codes whenever appropriate.
17	Payment adjusted because requested information was not provided or was insufficient/incomplete. Additional information is supplied using the RA remarks codes whenever appropriate.
18	Duplicate claim/service.
19	Claim denied because this is a work-related injury/illness and thus the liability of the worker's compensation carrier.
20	Claim denied because this injury/illness is covered by the liability carrier.

Code	Description
21	Claim denied because this injury/illness is the liability of the no-fault carrier.
22	Payment adjusted because this care may be covered by another payer, per coordination of benefits.
23	Payment adjusted because charges have been paid by another payer.
24	Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan.
25	Payment denied. Your stop loss deductible has not been met.
26	Expenses incurred prior to coverage.
27	Expenses incurred after coverage terminated.
28	OPEN.
29	The time limit for filing has expired.
30	Payment adjusted because the patient has not met the required eligibility, spend down, waiting, or residency requirements.
31	Claim denied as patient cannot be identified as our insured.
32	Our records indicate that this dependent is not an eligible dependent as defined.
33	Claim denied. Insured has no dependent coverage.
34	Claim denied. Insured has no coverage for newborns.
35	Benefit maximum has been reached.
38	Services not provided or authorized by designated (network) providers.
39	Services denied at the time authorization/pre-certification was requested.
40	Charges do not meet qualifications for emergent/urgent care.
41	OPEN.
42	Charges exceed our fee schedule or maximum allowable amount.
43	Gramm-Rudman reduction.
44	Prompt-pay discount.
45	Charges exceed your contracted/legislated fee arrangement.
46	OPEN.
47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.
48	OPEN.
49	These are non-covered services because this is a routine exam or screening procedure done in conjunction with a routine exam.
50	These are non-covered services because this is not deemed a, medical necessity, by the payer.
51	These are non-covered services because this is a pre-existing condition.
52	The referring/prescribing/rendering provider is not eligible to refer/prescribe/order/perform the service billed.
53	Services by an immediate relative or a member of the same household are not covered.
54	Multiple physicians/assistants are not covered in this case.
55	Claim/service denied because procedure/treatment is deemed experimental/investigational by the payer.

Code	Description
56	Claim/service denied because procedure/treatment has not been deemed, proven to be effective, by the payer.
57	Payment denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, this dosage, or this day's supply.
58	Payment adjusted because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.
59	Charges are adjusted based on multiple surgery rules or concurrent anesthesia rules.
60	Charges for outpatient services with this proximity to inpatient services are not covered.
61	Charges adjusted as penalty for failure to obtain second surgical opinion.
62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.
63	OPEN.
64	OPEN.
65	OPEN.
66	Blood Deductible.
67	OPEN.
68	OPEN.
69	Day outlier amount.
70	Cost outlier - Adjustment to compensate for additional costs.
71	OPEN.
72	OPEN.
73	OPEN.
74	Indirect medical education adjustment.
75	Direct medical education adjustment.
76	Disproportionate share adjustment.
77	OPEN.
78	Non-covered days/room charge adjustment.
79	OPEN.
80	OPEN.
81	OPEN.
82	OPEN.
83	OPEN.
84	OPEN.
85	Interest amount.
86	OPEN.
87	Transfer amount.
88	Adjustment amount represents collection against receivable created in prior overpayment.

Code	Description
89	Professional fees removed from charges.
90	Ingredient cost adjustment.
91	Dispensing fee adjustment.
92	OPEN.
93	OPEN.
94	Processed in excess of charges.
95	Benefits adjusted. Plan procedures not followed.
96	Non-covered charge(s).
97	Payment is included in the allowance for another service/procedure.
98	OPEN.
99	OPEN.
100	Payment made to patient/insured/responsible party.
101	Predetermination: Anticipated payment upon completion of services or claim adjudication.
102	Major medical adjustment.
103	Provider promotional discount (*e.g., senior citizen discount*).
104	Managed care withholding.
105	Tax withholding.
106	Patient payment option/election not in effect.
107	Claim/service denied because the related or qualifying claim/service was not paid or identified on the claim.
108	Payment reduced because rent/purchase guidelines were not met.
109	Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.
110	Billing date predates service date.
111	Not covered unless the provider accepts assignment.
112	Payment adjusted as not furnished directly to the patient and/or not documented.
113	Payment denied because service/procedure was provided outside the United States or as a result of war.
114	Procedure/product not approved by the Food and Drug Administration.
115	Payment adjusted as procedure postponed or canceled.
116	Payment denied. The advance indemnification notice signed by the patient did not comply with requirements.
117	Payment adjusted because transportation is only covered to the closest facility that can provide the necessary care.
118	Charges reduced for ESRD network support.
119	Benefit maximum for this time period has been reached.
120	OPEN.
121	Indemnification adjustment.

Code	Description
122	Psychiatric reduction.
123	OPEN.
124	OPEN.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the RA remarks codes whenever appropriate.
126	Deductible, major medical.
127	Coinsurance, major medical.
128	Newborn's services are covered in the mother's allowance.
129	Payment denied, prior processing information appears incorrect.
130	Claim submission fee.
131	Claim specific negotiated discount.
132	Prearranged demonstration project adjustment.
133	The disposition of this claim/service is pending further review.
134	Technical fees removed from charges.
135	Claim denied. Interim bills cannot be processed.
136	Claim adjusted. Plan procedures of a prior payer were not followed.
137	Payment/reduction for regulatory surcharges, assessments, allowances, or health related taxes.
138	Claim/service denied. Appeal procedures not followed or time limits not met.
139	Contracted funding agreement. Subscriber is employed by the provider of services.
140	Patient/insured health identification number and name do not match.
141	Claim adjustment because the claim spans eligible and ineligible periods of coverage.
142	Claim adjusted by the monthly Medicaid participant liability amount.
143	Portion of payment deferred.
144	Incentive adjustment, (*e.g., preferred product/service*).
A0	Patient refund amount.
A1	Claim denied charges.
A2	Contractual adjustment.
A3	OPEN.
A4	Medicare claim PPS capital day outlier amount.
A5	Medicare claim PPS capital cost outlier amount.
A6	Prior hospitalization or 30 day transfer requirement not met.
A7	Presumptive payment adjustment.
A8	Claim denied; ungroupable DRG.
B1	Non-covered visits.
B2	OPEN.

Code	Description
B3	OPEN.
B4	Late filing penalty.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.
B6	This payment is adjusted when performed/billed by this type of provider, in this type of facility, or by a provider of this specialty.
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.
B8	Claim/service not covered/reduced because alternative services were available, and should have been utilized.
B9	Services not covered because the patient is enrolled in a hospice.
B10	Allowed amount has been reduced because a component of the basic procedure/test was paid. The beneficiary is not liable for more than the charge limit for the basic procedure/test.
B11	The claim/service has been transferred to the proper payer/processor for processing. Claim/service not covered by this payer/processor.
B12	Services not documented in patients' medical records.
B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.
B14	Payment denied because only 1 visit or consultation per physician, per day is covered.
B15	Payment adjusted because this procedure/service is not paid separately.
B16	Payment adjusted because, new patient, qualifications were not met.
B17	Payment adjusted because this service was not prescribed by a physician, not prescribed prior to delivery, the prescription is incomplete, or the prescription is not current.
B18	Payment denied because this procedure code/modifier was invalid on the date of service or claim submission.
B19	OPEN.
B20	Payment adjusted because procedure/service was partially or fully furnished by another provider.
B21	OPEN.
B22	This payment is adjusted based on the diagnosis.
B23	Payment denied because this provider has failed an aspect of a proficiency testing program.
W1	Workers compensation state fee schedule adjustment.

2.4.4.3 Third Party Recovery (TPR) Fields on Paper Billing Forms

This table lists all the paper claim forms used by Idaho Medicaid and the fields used for TPR by number.

Form	Usual and Customary	Total Charges	Other Insurance	Balance Due	Comments
CMS-1500 claim form	24F.	28.	29.	30.	19.
	$ Charges	Total Charge	Amount Paid	Balance Due	Reserved for local use
UB-04 claim form	(not used)	23.	54.	55.	80.
		Enter the total of all claim charges	Prior Payments	Est. Amount Due	Remarks
Pharmacy claim form	(not used)	18.	19.	20.	21.
		Total Charges	Other Insurance Amount	Balance Due	Compound Drug Information
1999 ADA claim form	59.	59.	59.	(not used)	61.
	Fee	Total Fee	Payment by Other Plan		Remarks for Unusual Services

2.4.4.4 Unacceptable Denial Codes

A billing or timeliness error is not considered a, valid denial. The following are examples of denials that will not be accepted for either paper or electronic claims:

- Claim lacks information that is needed for adjudication.
- Patient cannot be identified as our insured.
- Claim filed past filing time limit.
- Duplicate of a previously submitted claim.

2.4.4.5 Medicaid Participation

If the insurance company made a payment toward the services, enter the amount of the payment in the appropriate field on the claim form. Medicaid will pay the balance of any remaining covered charges up to, but not exceeding, the amount allowed by Medicaid.

The following are examples of an insurance company (excluding Medicare) payment on Medicaid covered services.

1. Provider Billed Amount	$100.00
Medicaid Allowed Amount	80.00
Insurance Payment	80.00
Medicaid Payment	**0.00**

2. Provider Billed Amount	$100.00

Medicaid Allowed Amount	80.00
Insurance Payment	50.00
Medicaid Payment	**30.00**

3. Provider Billed Amount	$100.00
Medicaid Allowed Amount	80.00
Insurance Payment	90.00
Medicaid Payment	**0.00**

See *Section 2.5 Crossover Claims,* for more information.

2.4.5 Split Claims

Sometimes claims are billed to other insurance with more lines than will fit on the Medicaid paper claim form. To create a matching claim, the claim must be split.

If the other insurance's EOB has more detail lines than will fit on the claim form, divide the claim into two or more separate claims. Submit the first lines on one claim form and the remaining lines on additional claim forms.

Write *Split Claim*, in field **19** of the CMS-1500 claim form, field **80** of the UB-04 claim form, or field **61** of the ADA claim forms. Total each claim. Attach a separate copy of the EOB to each split claim.

Pro-rate the third party payments to match the lines billed.

Include a separate copy of the EOB with each split claim.

When billing electronically, it is not necessary to split a claim unless the provider is submitting more than the maximum number of details allowed on the claim.

- Dental claims: Up to 50 details.
- Professional claims: Up to 50 details.
- Institutional claims: Up to 999 details.

Note: ICD-9-CM codes **800** to **999** are injury diagnoses. For more on using diagnosis codes in this range, see *Section 2.4.6.2 Injury Diagnosis,* before submitting your claim. This helps prevent an unnecessary claim denial.

2.4.6 Injury Liability

All claims submitted with a diagnosis indicating injury will be reviewed for possible liability recoveries.

2.4.6.1 Confirming the Facts of an Injury

To prevent a claim from being denied for additional information on injuries, providers should submit letters of denials, maximums met, no liability, or other documentation, and include the following information with the claim:

- How the injury occurred.
- Where the injury occurred (home, someone else's home, work, commercial property, auto, etc.).
- When the injury occurred.
- Name and phone number of attorney, if applicable.

Indicate the information in field **19** of the CMS-1500 claim form, field **80** of the UB-04 claim form, or field **61** of the ADA claim forms. If the injury is not accident related, make note of this on the claim.

2.4.6.2 Injury Diagnosis

Investigate all possible third party involvement when a claim is denied due to injury diagnosis. Contact the participant and request additional information about the circumstances of the injury.

To process injury diagnosis claims, include the following information:

- Date of injury.
- How injury occurred.
- Indicate, *No TPL*, if investigation reveals no third party liability.

Include all documentation regarding the injury with the claim or on the electronic claim record, even if there are several claims for the same injury. Claims are reviewed separately and each stands on its own merit.

If investigation reveals no third party liability or shows the claim is not accident related, resubmit the claim to Medicaid for reconsideration. Include information regarding attempts made to identify a third party or accident information. The information must include that at least three attempts were made.

Document the person(s) to whom the provider spoke and the date and time of the contacts. Indicate this information in field **19** of the CMS-1500 claim form, field **80** of the UB-04 claim form, or field **61** of the ADA claim form. This information may also be listed in the first comment field of an electronic claim form.

2.4.7 Litigation Cases

There are two options for TPR cases that are in or going to litigation:

- Submit the claim to Medicaid with litigation details including the name of the attorney, if available. Medicaid will pay up to the allowed amount for the services billed.
- File a lien with the attorney for your charges. When a settlement has been reached, the provider may be reimbursed for the full amount of the charges, depending on the settlement amount and other liens or subrogations that may take precedence. When a provider chooses to bill the attorney and if a settlement occurs, regardless of the settlement amount, the provider may not bill Medicaid for those services after the one year billing date or if the provider receives a settlement.

Note: Medicaid payment is payment in full and providers may not collect from the settlement at a later date. Submit claims to Medicaid within the one year billing limit.

2.4.8 Third Party Recovery (TPR) Inquiries

Direct inquiries regarding TPR and insurance information to:

HMS
PO Box 2894
Boise, ID 83701
(208) 375-1132 in the Boise calling area
(800) 873-5875 (toll free)

Provider representatives are available Monday through Friday from 8 a.m. – 5:30 p.m. MT (excluding state holidays).

2.5 Crossover Claims

2.5.1 Overview

When a participant has both Medicare and Medicaid they are considered, dually eligible.

Participant's now have many options regarding Medicare. A participant may elect to be covered by Medicare Part A and/or Part B, or they may elect to purchase a Medicare Advantage Plan that is offered to the public through numerous insurance companies, or they may elect to participate in the Medicare-Medicaid Coordinated Plan (MMCP) available through Medicaid contracted insurance vendors.

For participant's who participate in the MMCP Program see *Section 1.4.7 Medicare-Medicaid Coordinated Plan (MMCP),* for billing information.

Claims that are billed and processed by Medicare and then sent to Medicaid for additional processing are called crossover claims.

A participant's Medicare information is available by calling MAVIS and choosing the, *Other Insurance*, menu option.

Each claim form must be submitted with a Medicare Remittance Notice (MRN) attached. The MRN must clearly state what was applied to the Medicare payment and any adjustments. Medicaid will pay at a maximum the difference between the Medicare payment and the Medicaid allowed amount or the Medicare co-insurance and/or deductible, whichever is less.

If the MRN does not clearly identify that it is a MRN, write on the top right margin of the claim or the MRN, *Medicare MRN*, to help sort the claim or *Medicare HMO,* if applicable.

2.5.2 Billing Medicare

Providers must bill Medicare first for services rendered to participants who are both Medicare and Medicaid eligible.

2.5.2.1 Part A Crossover Claims — Hospital

Providers must bill Medicare Part A intermediaries before billing Idaho Medicaid.

2.5.2.2 Part B Crossover Claims — Hospital

Hospitals submitting claims for Part B only participants must first bill the Medicare carrier for any Part B services before billing Idaho Medicaid.

Part B services include:

- Laboratory.
- Radiology.
- Nuclear medicine.
- Electrocardiogram (EKG).
- Speech therapy.
- Physical therapy.
- Prosthetic devices.
- Pulmonary function tests.
- Surgical supplies.
- Catheters.

2.5.2.3 Split Claims

Sometimes claims are billed to Medicare with more lines than will fit on the Medicaid paper claim form. To create a matching claim, the claim must be split.

If the Medicare MRN has more detail lines than will fit on the claim form, split the claim. Submit two claims with the first lines on one claim form and the remaining lines on additional claim forms.

Write, *Split Claim*, in field **19** of the CMS-1500 claim form or in field **80** of the UB-04 claim form. Leave the fields for amount paid and balance due blank. Attach a separate copy of the EOMB to each split claim. Total each claim.

When billing electronically, it is not necessary to split a claim unless the provider is submitting more than the maximum number of details allowed on the claim.

- Dental claims: Up to 50 details.
- Professional claims: Up to 50 details.
- Institutional claims: Up to 999 details.

2.5.3 Crossover Errors

Occasionally, a claim does not automatically cross over to EDS. This occurs when the Medicare and Medicaid participant numbers on file do not match. If a claim does not appear on the Medicaid remittance advice (RA) within four weeks after Medicare payment, submit the claim for processing. Call EDS Provider Enrollment to verify that all provider numbers are on file to allow for automatic crossover.

2.5.4 Resubmitting Crossover Claims

Crossover claims returned to the provider for any reason must be resubmitted. Attach the original claim and any other supporting documentation to a copy of the MRN. Be sure to include your provider number and the participant's Medicaid identification (MID) number.

The claim dates of service, billed amounts and the MRN must match. Occasionally, Medicare combines or splits claims to expedite processing. When this happens, change the Medicaid claim form to match the Medicare remittance. The services Medicare processes as a single claim under one claim number must match exactly the service billed on the claim submitted to Medicaid.

Lab services are usually paid at 100 percent of the approved amounts. The claim total will differ from the total billed on the MRN if you do not bill these charges to Medicaid. A notation on a claim, in field **19** of the CMS-1500 claim form stating that, *the lab charges were paid*, reduces the chance of a claim being returned in error.

Note: Providers who qualify for Medicare payment but have not applied to Medicare must register their National Provider Identifier (NPI) with Medicare and bill Medicare before billing Medicaid for all Medicare-covered services. See *Section 2.5.6 Medicare/Medicaid Crossover Inquiries,* for Medicare phone numbers and addresses.

2.5.5 Qualified Medicare Beneficiaries (QMB) Medicare/Medicaid Billing Information

Participants, who are only enrolled as QMB, are only eligible for Medicare covered services up to Medicare's allowed amount from Idaho Medicaid. Claims filed secondary to Medicare are called, crossover claims. On the RA, the payment of these charges appears on the first detail line of the paid claim on the, Professional Crossover Claim page.

Services denied or not covered by Medicare for QMB participants will be denied if billed to Medicaid. Services denied or not covered by Medicare for participants who are, dually eligible, may be submitted electronically or on a separate paper form. These claims are not considered crossover claims. Medicaid processes these charges as the primary payer.

Each claim form must be submitted with a MRN attached. All crossover claims submitted on paper must match the MRN exactly.

When an MRN contains covered and non-covered services (for dually eligible QMB participants only), submit two separate claims to Medicaid;

- One claim for the covered Medicare crossover portion with the MRN attached.
- Second claim for the non-covered Medicare services with the MRN denial attached.

Indicate, *Medicare Non-Covered Benefit*, in comments or remarks field of your claim form.

See *Section 1.4.6 Medicare Savings Program,* for more information.

2.5.5.1 Electronic Crossover Claims

Medicare Part B services billed by Idaho Medicaid providers crossover electronically from the Medicare intermediary and carrier to EDS. This process occurs automatically when the Medicare claim shows:

- Assignment was accepted.
- Participant's Idaho MID number.
- Provider's Medicare number.

Provider may submit Part B services directly to Idaho Medicaid if their software supports crossover billing.

2.5.5.2 Paper Crossover Claims

Information on crossover claims submitted on paper must match the information on the MRN exactly. The dates of service and dollar amounts must be the same as are on the MRN. File a separate claim for each claim on the MRN. Participants with both Medicare and private insurance must have an Explanation of Benefits (EOB) from both carriers attached to the Medicaid claim form.

When billing paper crossover claims:

- Use the participant's Idaho MID number.
- Use the Idaho Medicaid provider number.
- Fill in all of the same required fields as on non-crossover claims.
- Sign and date all claims.
- Attach the MRN to the claim and make sure that the MRN is clearly identified as Medicare, Medicare HMO, or Medicare Supplement on the claim form or MRN.
- Make sure all attachments are on 8½" x 11" paper.

If the participant is not Medicaid eligible for a certain date of service, do not enter those charges on the claim. Put a note on the front of the claim explaining that this is why the MRN does not match the claim.

2.5.6 Medicare/Medicaid Crossover Inquiries

For inquiries regarding Medicare/Medicaid crossover claims, write or call the related intermediary listed below.

Part A Medicare:
Noridian Administrative Services
PO Box 6726
Fargo, ND 58108-6726

Provider Number: (877) 908-8437 or (877) 425-2371 TTY
Beneficiary Number: (800) 633-4223 or (800) 633-4227

Part B Medicare:
CIGNA
PO Box 22599
Nashville, TN 37202

Provider Number: (866) 520-4007 or (615) 782-4509 (toll call)
Participant Number: (800) 627-2782

CIGNA Health Care: DMERC, Region D
All durable medical equipment (DME), immunosuppressive drugs, enternal/parenternal nutrients (PEN), prosthetics, orthotics, and supplies.

CIGNA DMERC — Region D
PO Box 690
Nashville, TN 37202
Provider Number: (866) 243-7272
Participant Number: (800) 899-7095

2.6 Adjustments

2.6.1 Overview

When a claim is paid incorrectly, submit an adjustment request to EDS. Incorrect payments may result from changes to information received after initial payment (*e.g.*, third party resource payments or changes in nursing home participant liability amounts), provider billing errors, or claims processing errors.

Adjustments can be done only on paid claims or paid claim details. These are claims that are listed in the, paid claims, section of the remittance advice (RA). See *Section 4 Remittance Advice (RA) Guidelines,* for more information.

Providers have two years after the calendar quarter in which the payment was received to request an adjustment. In accordance with the provider agreement, providers are required to immediately repay identified overpayments.

Paid claims can be adjusted with either a paper adjustment request form or through electronic billing software. Writing, *Corrected Claim*, on a paper claim will not fix the earlier claim error. This new claim will be denied as a duplicate claim. Using the paper form, the provider corrects specific details. Using the electronic form, the provider voids the original claim and submits a new claim with corrected information.

Note: Do not send a copy of the RA or a copy of the original claim with the adjustment.

Electronic Adjustments: Providers can submit electronic adjustments to EDS using PES or their vendor software. When submitting electronic adjustments, use claim frequency 8 to void a claim, and claim frequency 7 to replace a claim.

2.6.1.1 Electronic Claim Void & Replacements

Claim void and replacements are the electronic equivalent of the paper adjustment process. Providers can submit electronic void and replacements to EDS using PES or their vendor software. See the *Provider Electronic Solutions (PES) Handbook* or vendor software instructions for more information.

2.6.1.2 Paper Adjustments

Claims can be adjusted with the Adjustment Request form. Use this form to refund an overpayment, request increased payment, or to make corrections to claim information. When completing the adjustment request form, clearly state the correct billing information for the detail or claim to be adjusted.

A copy of the Adjustment Request form with full instructions can be found in *Appendix D; Forms*. See the table for examples of claim errors that can be corrected on this form.

Note: Only one claim can be corrected with each Adjustment Request form. See table for examples.

Error on claim	On the adjustment form state…
1. A service listed on the first detail line was billed for the wrong date.	Date on line 1 should be 11/24/2002.
2. A service listed on the third detail line was billed as two units, but should have been billed as four units.	Detail 3 was billed as two units and it should be four units.
3. A service that was not performed was incorrectly listed on the fourth detail line.	No services done for line 4. Void this detail.

Error on claim	On the adjustment form state…
4. An insurance payment was received after the claim was submitted to Medicaid.	Insurance paid $156.32.
5. A claim was billed under the incorrect provider or participant number.	Please void this claim.

If the above examples 1 through 4 were actually on one claim, the claim should be voided. Example 5 can never be adjusted and the claim must be voided. To do this, the provider would:

- Select the option: Please withhold overpayment in a future Medicaid warrant with an adjustment.
- Note on the adjustment form that the claim is to be voided.

As a result, the original claim would be voided in the following week's RA and the provider could then submit the corrected claim for payment. The corrected claim cannot be submitted until the voided claim is reported on an RA.

2.6.2 Denied Claims

If a claim is denied (appears in the, Denied Claims, section of the RA), the claim must be resubmitted with any corrections that are needed to obtain payment. EDS cannot adjust denied claims or claims in-process.

Denied claims or a denied claim detail cannot be adjusted; however they can be resubmitted, either electronically or on paper, with corrections as a new day claim. It is not necessary to adjust a denied detail line on a claim if the payment of the detail would have no effect on the payment of the other lines on the claim or would not be affected by consideration of the other lines on the claim.

Example: On a surgical claim where one line with multiple surgeries was denied, the denied detail should be corrected and only that line resubmitted. On an inpatient hospital claim where a detail revenue code was denied that would need to be processed with the accommodation charge, the line should be corrected and resubmitted to EDS for processing as a new claim.

2.6.3 Adjustment Forms

Form Available: An Adjustment Request form with complete instructions is included in *Appendix D; Forms.* It can be copied for use as needed.

2.6.3.1 Where to Mail an Adjustment Request

Mail all adjustment requests to:

EDS
Claims Adjustments
PO Box 23
Boise, ID 83707-0023

Note: Do not fax Adjustment Request forms. They will be returned to the sender.

2.6.4 Appeals

To request a review of the reimbursement amount of a particular service, submit a written request to the EDS Correspondence Team. Include the following:

- Provider number.
- Reason you feel you were not properly reimbursed.
- Supporting documentation.

EDS will review the payment amount and send a written explanation if the claim was processed correctly.

To appeal EDS' review or request a review of the reimbursement amount of a particular service, send a written request for appeal to the Department of Health and Welfare (DHW).

Include the following information with the appeal:

- Copy of EDS' review notice.
- Copy of Adjustment Request form, if applicable. (Do not send an Adjustment Request form if the original claim(s) was denied.)
- Copy of original claim and all attachments, and new claim for possible resubmission.

Medicaid will review the claim and respond in writing with their determination.

Mail appeals to:

Medicaid Claim Appeals
Attn: Office of Medicaid Automated Systems (MAS)
PO Box 83720
Boise, Idaho 83720-0036